National Medicaid EDI Healthcare Workgroup (NMEH)
Resulting White Paper from X12N-TG2-WG5
Action Item for NMEH to approve white paper for
Claims Status Solution
February 2002 X12 Conference

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White Paper -- Reporting Pended Claims
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Background:
Claims are input to health care systems via Professional, Institutional, and Dental claim formats (whether proprietary and/or HIPAA formats). The results of the processing or adjudication of the claim can be viewed by the processing status of:

- Approved – this status indicates that the claim will be paid. The explanation of what exactly is paid is recorded in the claim remittance advice that is produced (either on paper, electronic, or both) by the payer and sent to the provider (or sender).
- Rejected – this status indicates that the claim was rejected by the payer's system.
- Denied – this status indicates that the claim is denied by the payer.
- Pended – this status indicates that the claim is pending on the payer's system due to incomplete information, policy questions, legislative issues, or other issues determined by the payer. This may include, but is not limited to, such actions as manual review for medical necessity or pricing. The payer may also request further information from the provider using the ASC X12N 277 004020X104 Health Care Claim Request for Additional Information.

During migration and analysis of transitioning to the HIPAA Standard Guides, there is a clear and concise mapping of Approved, Rejected, and Denied statuses to the 835 remittance advice. The Pended status is noted in the 835 Implementation Guide (CLP02, data element 1029, Claim Status Code values 5, 10, 13, 15, 16, 17, and 27) as "NOT ADVISED" and "Claims with this status should be reported in the claim status (277) transaction when the payer implements it". At the time of publication of the 004010X091 835 transaction, the 277 transaction that was "understood" to be referenced in the 835 Implementation guide was a "draft" implementation guide that was titled "Unsolicited 277 Claim Status".

As of fourth quarter 2001, it was determined by the claims status workgroup in X12N (TG2-WG3) that the "Unsolicited 277 Claim Status" transaction was only needed for one

segment of the healthcare industry (Medicaid) and further development of the guide has been discontinued.

During the informational forum hosted by the claims status workgroup at the February 2002 X12N Workgroup meetings, it was clarified by TG2-WG5 that work has been stopped on the Unsolicited 277 Claim Status and the development of the 277 Front-end Acknowledgement Transaction is the focus of TG2-WG5's efforts. The X12N project plan was updated and internal X12N meetings with the Implementation Guide Task Group (IGTG) led to the recommendation to split the Front End Acknowledgement and the Pended/Suspended Claim Reporting. The Front End Acknowledgement business purpose was incorporated into the Version 4040 of the X070 Implementation Guide Project Plan and the pended/suspended references were removed.

Situation:
Medicaid states have policies and/or state laws that require reporting claims that are in a pended status to the provider at the time of remittance or in an agreed upon timely fashion. With efforts to publish the "Unsolicited 277 Claim Status" Implementation Guide having ceased and by the new focus of the TG2-WG5 to create the Front-end 277 claim status, there is <u>not</u> a clear and concise solution to report pended claims after claims adjudication.

Proposed Solutions:

Solution 1: At the claims status informational forum and workgroup meetings at the X12N conference in February 2002, the co-chairs from TG2-WG5 have entertained for positive consideration and review use of the 277 from the 276/277 X093 HIPAA Implementation Guide.

The payer creates 277 transactions using the 837 and adjudication data as the source data to report pended claims status in the format that is described in the X093 276/277 Implementation Guide for formatting the 277. The 277 claims can be "packaged" one of two ways:

A. Include the 277 transactions in the same transmission envelope where the 835 transaction is generated.

ISA
GS
ST
(835)
SE
GE

GS
ST
(277)
SE
GE
IEA

B. Create a separate transmission that only reports 277 transactions back to the provider as pended by the adjudication system.

ISA
GS
ST
(277)
SE
GE
IEA

Possible Gaps and/or Issues with the solution:

1. The comparison between the draft unsolicited 277 and the 277 portion of the X093 276/277 transaction set revealed four situations that were different:

	277/276 IMPLEMENTATION GUIDE				U277 IMPLEMENTATION GUIDE		
Situation Number	**Loop**	**Segment**	**Description**		**Loop**	**Segment**	**Description**
1	2100A	PER	Payer Contact Info		2100	N3	Payer Street Address
						N4	Payer City/State/Zip
2	(No similar references found)				2100	N3	Receiver Street Address
						N4	Receiver City/State/Zip
3	2000D	DMG	Subscriber DMG Info		2100	N3	Subscriber Street Address
						N4	Subscriber City/State/Zip
4	2000E	DMG	Dependent DMG Info		2100	N3	Dependent Street Address
						N4	Dependent City/State/Zip

All of the information that refers to the claim(s) being identified by the 277 is the same for the 2 versions. In other words, the 2 versions of the 277 contain the exact same segments that will describe the claim(s).

2. The TG2-WG5 co-chairs identified an additional issue:
   What value is to be used in the GS08 data element?
   Recommendation (from TG2-WG5) is to use the version and release number excluding the Industry Identifier code because the transaction is not a HIPAA covered transaction. Example: 004010 as opposed to 004010X093. Use of only the version and release should be included in the trading partner agreement between entities.

Solution 2:

As noted above, a claim is pended in the adjudication process due to incomplete information, policy questions, legislative issues, or other issues determined by the payer. A case can be made that the business purpose for the ASC X12N 277 004020X104 Health Care Request for Additional Information is to notify the provider that

a claim has not been completely adjudicated *pending* receipt of further information. The payer may be seeking further information:

A. *From the provider* or
B. *From internal sources.*

The juncture in the adjudication cycle where this business purpose arises is likely the same, especially to the extent that we can automate the process for determining that additional information is required.

Currently, the 277 Health Care Request for Additional Information supports this business purpose in part (A) by notifying the provider that a claim is pended and requesting the provider to send additional clinical information. The 277 Health Care Request for Additional Information could fully support this business purpose (B) if we modified the STC segment at page 69 of the 004020X104 implementation guide. To facilitate this business process, the following changes would need to be made:

- STC01-1 Health Care Claim Status Category Code - allow the use of additional Category Codes for "pended" claims that tell the provider what type of information the payer is seeking internally.
- STC01-2 Industry Code – allow use of claim status codes for "pended" for internal review only claims
- STC01-3 Entity Identifier Code – allow use of this data element for "pended" for internal review only claims. Include the value list included in the 277 X093 implementation guide
- STC01-4 Code List Qualifier – add value of "65" Health Care Claim Status Code for use with "pended for internal review only claims.

The guide could limit the permissible codes to those relating to reasons that a payer has pended the claim, further information the payer requires to proceed, and//or actions the payer intends to take. Examples are:

40	Waiting for final approval.
41	Special handling required at payer site.
42	Awaiting related charges.
44	Charges pending provider audit.
45	Awaiting benefit determination.
46	Internal review/audit.
47	Internal review/audit - partial payment made.
48	Referral/authorization.

49	Pending provider accreditation review.
50	Claim waiting for internal provider verification.
51	Investigating occupational illness/accident.
52	Investigating existence of other insurance coverage.
53	Claim being researched for Insured ID/Group Policy Number error.
55	Claim assigned to an approver/analyst.
56	Awaiting eligibility determination.
57	Pending COBRA information requested.

This may be a better solution in the long term but requires going through the HIPAA standards protocol.

Solution #3
Propose the 3070 version of the 277 Unsolicited Claims Status Roster to progress to version 4050.

This would involve following the X12N protocol to get the original document approved. In the meantime, some states are willing to take the risk and have elected to go ahead and use this document as the vehicle to report pended claims.

Solution #4
Health care organizations to establish separate trading partner agreements to report pended claims one of two ways:

Use the previous 3 solutions on their own terms
Use the pended status in the 835 transaction.

The questions for X12N-WG5 -- Claims Status Workgroup are:

1. What is the impact of the use of the 277 in the proposed solutions to the X12N processes?
2. What other “protocol”, if any, does X12N require to “support” or at the very least … not oppose the proposed solutions?

3. Is it appropriate for trading partners to agree to use the 277 to report pended claims in the proposed solutions?
4. The paragraph in Section 1.3 (X093) states: "Separate implementation guides were developed to detail using the 277 Health Care Payer Unsolicited Claim Status and the 277 Health Care Claim Request for Additional Information." Since the TG2-WG5 has decided to stop work on the unsolicited guide, will this paragraph have to be modified?
5. Section 1.3.2.2 describes the status of "Claim(s) Pended for Development or Suspended for Additional Information". Since the 277 Health Care Claim Request for Additional Information has grown into specific business use of "Claims Attachments". Should the proposed solution be referenced instead?
6. To use solution #2, would the industry have to wait for the 277-Request for More Information to be HIPAA approved?
7. Since the Attachment NPRM is not scheduled for release until late 2002, how are payers expected to continue their business processes and report pended claims in a compliant fashion?
8. Will WG5 be conducting formal outreach to "all" health care payer organizations for a more representative viewpoint from the health care industry on this issue of reporting pended claims?